ACCREDITATION

Required Organizational Practice (ROP) of the Month

PATIENT SAFETY INCIDENT MANAGEMENT

- The Required Organizational Practice (ROP) states a **patient safety management system** that supports reporting and learning is implemented. This ROP is part of the **Leadership Standards**.
- The patient safety management system includes processes to report, analyze, recommend actions and monitor improvements.
- In a culture of patient safety, everyone is encouraged to report and learn from patient safety incidents, including harmful, no harm and near miss.

AT HEALTH PEI:

- There is **Patient Safety Incident Reporting and Management Policy** to guide the practice of reporting and managing patient safety incidents.
- Incidents are documented in the electronic **Provincial Safety Management System (PSMS).**
- Training is provided to staff on how to enter incidents and incident analysis/follow-up.
- **Patient and family feedback** can be submitted online and is recorded in PSMS.
- The **Patient Safety Incident Quality Review and Quality Improvement Activity Policy** guides the review and analysis of harmful or complex incidents, focusing on system improvement.
- **Trending reports** from PSMS are regularly analyzed to identify actions that enhance safety and quality.

Patient safety incident reporting is an essential component of Health PEI's commitment to safe, high-quality patient care.

For more information on incident reporting, visit the Patient Safety Page on the Staff Resource Centre
https://src.healthpei.ca/incident-reporting

Questions Surveyors May Ask Staff:

Is there a policy on incident reporting and management? Where can I find it?

What is an example of a patient safety incident?

What is a near miss? What is the benefit of reporting a near miss?

Have there been changes to policy or practice because of a reported patient safety incident?

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